UPDATED PAO MEMBER DEMOGRAPHICS

YEAR: 2017 (paoform1)

PLEASE ANSWER COMPLETELY.

NAME:_____
Last name First Name Middle Name

PERMANENT RESIDENCE:_____

_____

_____

CONTACT NUMBER: (home) _____

(Mobile no. /s) _____

PRC#: _____ **PHIC #:** _____

PMA Membership #: _____ **PMA Component Society & #:** _____

BIRTHDAY: _____ **GENDER**: _____ (0) MALE
month/day/year _____ (1) FEMALE

TYPE OF PAO MEMBERSHIP: _____ (0) FELLOW

_____ (1) DIPLOMATE

_____ (2) ASSOCIATE

_____ (3) MEMBER IN TRAINING

TYPE OF PRACTICE: _____ (0) PRIVATE
_____ (1) GOVERNMENT
_____ (1A) visiting
_____ (1B) with item/plantilla
_____ (1B.1) full time
_____ (1B. 2) part-time
_____ (1C) contractual
_____ (2) BOTH PRIVATE & GOVT (please answer likewise what type of gov't. service – item just above)

SUBSPECIALTY: _____ (0) GENERAL OPHTHALMOLOGY:
_____ (0A) medical practice only
_____ (0B) medical & surgical
_____ (1) purely SUBSPECIALTY: _____
_____ (2) BOTH General Ophthalmology and Subspecialty **(PLEASE INDICATE)**

MEMBERSHIP TO A PAO LOCAL CHAPTER SOCIETY: _____ (0) yes _____ (1) no

If yes, pls. state the local chapter society:_____

PLACE OF PRACTICE:

Example:

1. MAIN CLINIC:
   UST Hospital Rm 424 Doctors' Clinics
   Espana Street, Sampaloc Manila
   Clinic Phone: 7313001 loc. 2277

2. OTHERS:
   a. Marian Fairview Doctors Clinics – Rm 401
      Regalado corner Commonwealth Streets, Fairview , Quezon city
      Clinic Phone: 5523103
      Sched: M/W/F 3:00pm – 5:00pm
   b. ABCEDE Eye Center
      21 Regedor St. corner A. Bonifacio Sts., Lucban Quezon
      Clinic Phone: (042) 8161440
      Sched: T/TH/S 9:00pm – 12:00nn

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1. MAIN CLINIC: *(pls. provide complete name of clinic, full address, phone number)*

2. OTHERS:

* * * Thank you for your participation. * * *